

**DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington**

To: Pharmacies
All Prescribers
Managed Care Plans
Nursing Home Administrators

Memorandum No: 04-65 MAA
Issued: August 30, 2004

For More Information, call:
1-800-562-6188

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration

Subject: Prescription Drug Program: Preferred Drug List and Expedited Prior Authorization Updates

Effective the week of September 1, 2004, and after (unless otherwise noted), the Medical Assistance Administration (MAA) will implement the following changes to the Prescription Drug Program:

- Addition of Therapeutic Drug Classes to the Washington Preferred Drug List; and
- Expedited Prior Authorization changes.

Addition of Therapeutic Drug Classes to the Washington Preferred Drug List

Therapeutic Drug Class	Preferred Drugs	Nonpreferred Drugs
Urinary incontinence drugs	Generic oxybutynin tablets	Ditropan brand, Ditropan XL, Detrol, Detrol LA, Urispas, and Oxytrol patch
Skeletal muscle relaxants	Generic baclofen, cyclobenzaprine and methocarbamol	carisoprodol, chlorzoxazone, Dantrium, brand Flexeril, brand Lioresal, brand Norflex, orphenadrine, brand Robaxin, Skelaxin, tizanidine

Changes to Expedited Prior Authorization Criteria

Drug	Code	Criteria
Copegus® (<i>Ribavirin</i>) Rebetol® (<i>Ribavirin</i>) Ribavirin	010	Diagnosis of chronic hepatitis C infection in patients 18 years of age or older. Patient must be on concomitant alpha interferon or pegylated alpha interferon therapy (not to be used as monotherapy).

Effective the week of September 6, 2004, and after:

Drug	Code	Criteria
Concerta® (<i>Methylphenidate</i>) Focalin® (<i>Dexmethylphenidate</i>) Metadate CD® (<i>Methylphenidate</i>) Ritalin LA® (<i>Methylphenidate</i>)	026	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) and the prescriber is an authorized schedule II prescriber.

Clarification on Non-preferred Drug Claim Denials

The primary NCPDP return message may not clearly reflect the reason your claim was denied. In all instances where a non-preferred drug is denied, a secondary message is provided that has further explanation of the denial. If you have trouble viewing, or are unaware of how to access the secondary message, please contact your software vendor.

Billing Instructions Replacement Pages

Attached are replacement pages H.7-H.14 for MAA's Prescription Drug Program Billing Instructions, dated February 2003.

Prescription Drug Program

Drug	Code	Criteria
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Abilify® 015 All of the following must apply:
(Aripiprazole)

- a) There must be an appropriate DSM IV diagnosis; and
- b) Patient is 6 years of age or older.

Accutane®
(Isotretinoin)

Must not be used by patients who are pregnant or who may become pregnant while undergoing treatment. The following conditions must be **absent**:

- a) Paraben sensitivity;
- b) Concomitant etretinate therapy; and
- c) Hepatitis or liver disease.

001 Diagnosis of severe (disfiguring), recalcitrant cystic acne, unresponsive to conventional therapy.

002 Diagnosis of severe, recalcitrant acne rosacea in adults unresponsive to conventional therapy.

003 Diagnosis of severe keratinization disorders when prescribed by, or in consultation with, a dermatologist.

004 Prevention of skin cancers in patients with xeroderma pigmentosum.

005 Diagnosis of mycosis fungoides (T-cell lymphoma) unresponsive to other therapies.

Drug	Code	Criteria
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Adderall® 026 Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) of Attention Deficit Disorder (ADD) and the prescriber is an authorized schedule II prescriber.
(Amphetamine/
Dextroamphetamine)

027 Diagnosis of narcolepsy by a neurologist or sleep specialist, following documented positive sleep latency testing and the prescriber is an authorized schedule II prescriber.

087 Depression associated with end stage illness and the prescriber is an authorized schedule II prescriber.

Adderall XR® 094 Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) and all of the following:
(Amphetamine/
Dextroamphetamine)

- a) The prescriber is an authorized schedule II prescriber; and
- b) Total daily dose is administered as a single dose.

Adeks® 102 For the treatment of malabsorption conditions, especially those conditions that inhibit the absorption of fat-soluble vitamins (such as cystic fibrosis, steatorrhea, hepatic dysfunction, and cases of HIV/AIDS with malabsorption concern) and all the following:
Multivitamins

- a) Patient is under medical supervision; and
- b) Patient is not taking oral anticoagulants; and
- c) Patient does not have a history of or is not at an increased risk for stroke/thrombosis.

Prescription Drug Program

Drug	Code	Criteria
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Aggrenox® 037 To reduce the risk of stroke in patients who have had transient ischemia of the brain or completed ischemic stroke due to thrombosis, and all of the following:

- a) The patient has tried and failed aspirin or dipyridamole alone; and
- b) The patient has no sensitivity to aspirin.

Altace® 020 Patients with a history of cardiovascular disease.
(Ramipril)

Ambien® 006 Short-term treatment of insomnia. Drug Therapy is limited to 10 in 30 days, after which the patient must be re-evaluated by the prescriber before therapy can be continued.
(Zolpidem tartrate)

Angiotensin Receptor Blockers (ARBs) 092 Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.

Atacand® (Candesartan cilexetil)
Atacand HCT® (Candesartan cilexetil/HCTZ)
Avalide® (Irbesartan/HCTZ)
Avapro® (Irbesartan)
Benicar® (Olmesartan medoxomil)
Cozaar® (Losartan potassium)
Diovan® (Valsartan)
Diovan HCT® (Valsartan/HCTZ)
Hyzaar® (Losartan potassium/HCTZ)
Micardis® (Telmisartan)
Micardis HCT® (Telmisartan/HCTZ)
Teveten® (Eprosartan mesylate)
Teveten HCT® (Eprosartan mesylate/HCTZ)

Anzemet® 127 Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.
(Dolasetron mesylate)

Drug	Code	Criteria
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Avinza® 040 Diagnosis of cancer-related pain.
(Morphine sulfate)

Calcium w/Vitamin D 126 Confirmed diagnosis of osteoporosis, osteopenia or osteomalacia.

Clozapine Clozaril® 018 All of the following must apply:

- a) There must be an appropriate DSM IV diagnosis present as determined by a qualified mental health professional; and
- b) Patient is 17 years of age or older; and
- c) Must be prescribed by a psychiatrist, neurologist, or psychiatric ARNP with prescriptive authority approved for this drug class, or in consultation with one of the above.

Concerta® 026 Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) and the prescriber is an authorized schedule II prescriber.
(Methylphenidate HCl)

Copegus® 010 Diagnosis of chronic hepatitis C virus infection in patients 18 years of age or older. Patient must be on concomitant alpha interferon or pegylated alpha interferon therapy (not to be used as monotherapy).
(Ribavirin)

Dexedrine® See criteria for Adderall®.
(D-Amphetamine sulfate)

Dextrostat® See criteria for Adderall®.
(D-Amphetamine sulfate)

Duragesic® 040 Diagnosis of cancer-related pain.
(Fentanyl)

Focalin® See criteria for Concerta®.
(Dexmethylphenidate HCl)

Prescription Drug Program

Drug	Code	Criteria
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Geodon® 046 All of the following must apply:
(Ziprasidon)
a) There must be an appropriate DSM IV diagnosis; and
b) Patient is 6 years of age or older.



Note: Because Geodon® prolongs the QT interval (< Seroquel® > Risperdal® > Zyprexa®), it is contraindicated in patients with a known history of QT prolongation (including a congenital long QT syndrome), with recent acute myocardial infarction, or with uncompensated heart failure; and in combination with other drugs that prolong the QT interval.

Infergen® 134 Treatment of chronic hepatitis C
(Interferon alfacon-1) in patients 18 years of age and older with compensated liver disease who have anti-HCV serum antibodies and/or presence of HCV RNA.

Intron A® 030 Diagnosis of hairy cell leukemia
(Interferon alpha-2b recombinant) in patients 18 years of age and older.

031 Diagnosis of recurring or refractory condyloma acuminata (external genital/perianal area) for intralesional treatment in patients 18 years of age and older.

032 Diagnosis of AIDS-related Kaposi's sarcoma in patients 18 years of age and older

033 Diagnosis of chronic hepatitis B in patients 1 year of age and older.

107 Diagnosis of malignant melanoma in patients 18 years of age and older.

109 Treatment of chronic hepatitis C in patients 18 years of age and older.

135 Diagnosis of follicular non-Hodgkin's lymphoma in patients 18 years of age and older.

Kadian® 040 Diagnosis of cancer-related pain.
(Morphine sulfate)

Drug	Code	Criteria
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Kytril® 127 Prevention of nausea or vomiting
(Granisetron) associated with moderately to highly emetogenic cancer chemotherapy.

128 Prevention of nausea or vomiting associated with radiation therapy.

Lamisil® Treatment of onychomycosis for
(Terbinafine) up to 12 months per nail is covered if patient has one of the following conditions:

042 Diabetic foot;

043 History of cellulites secondary to onychomycosis and requiring systemic antibiotic therapy; or

045 Fingernail involvement with or without chronic paronychia.

Levorphanol 040 Diagnosis of cancer-related pain.

Marinol® 035 Diagnosis of cachexia
(Dronabinol) associated with AIDS

036 Diagnosis of cancer and failure of all other drugs to adequately treat nausea and vomiting related to radiation or chemotherapy.

Metadate CD® See criteria for Concerta®.
(Methylphenidate HCl)

Miralax® 021 Treatment of occasional
(Polyethylene glycol constipation. Must have tried and 3350) failed a less costly alternative.

Naltrexone See criteria for ReVia®.

Prescription Drug Program

Drug	Code	Criteria
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Nephrocaps® 096 Treatment of patients with renal disease.

Nephro-FER®

(Ferrous Fumarate/
Folic acid)

Nephro-Vite®

Vitamin B Comp W-C)

Nephro-Vite RX®

(Folic acid/Vitamin B
Comp W-C)

Nephro-Vite+FE®

(Fe Fumarate/FA/
Vitamin B Comp W-C)

Nephron FA®

(Fe fumarate/Doss/
FA/B Comp & C)

Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) 141 An absence of a history of ulcer or gastrointestinal bleeding.

Ansaid® (Flurbiprofen)

Arthrotec® (Diclofenac/misoprostol)

Bextra® (Valdecoxib)

Cataflam® (Diclogencic)

Celebrex® (Celecoxib)

Clinoril® (Sulindac)

Daypro® (Oxaprozin)

Feldene® (Piroxicam)

Ibuprofen

Indomethacin

Lodine®, Lodine XL® (Etodolac)

Meclofenamate

Mobic® (Meloxicam)

Nalfon® (Fenoprofen)

Naprelan®, Naprosyn® (Naproxen)

Orudis®, Oruvail® (Ketoprofen)

Ponstel® (Mefenamic acid)

Relafen® (Nabumetone)

Tolectin® (Tolmetin)

Toradol® (Ketorolac)

Vioxx® (Rofecoxib)

Voltaren® (Diclofenac)

Oxandrin® Before any code is allowed, there must be an absence of all of the following:

(Oxandrolone)

- a) Hypercalcemia;
- b) Nephrosis;
- c) Carcinoma of the breast;
- d) Carcinoma of the prostate; and
- e) Pregnancy.

Drug	Code	Criteria
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110 Treatment of unintentional weight loss in patients who have had extensive surgery, severe trauma, chronic infections (such as AIDS wasting), or who fail to maintain or gain weight for no conclusive pathophysiological cause.

111 To compensate for the protein catabolism due to long-term corticosteroid use.

112 Treatment of bone pain due to osteoporosis.

OxyContin®

(Oxycodone HCl)

040 Diagnosis of cancer-related pain.

PEG-Intron®

(Peginterferon
Alpha 2b)

109 Treatment of chronic hepatitis C in patients 18 years of age or older.

Pegasys®

(Peginterferon
Alpha-2a)

109 Treatment of chronic hepatitis C in patients 18 years of age or older.

Plavix®

(Clopidogrel
bisulfate)

136 For use in patients with atherosclerosis documented by recent myocardial infarction, recent stroke, or established peripheral artery disease and have failed aspirin. A patient that is considered an aspirin failure has had an atherosclerotic event (MI, stroke, intermittent claudication) after the initiation of once-a-day aspirin therapy.

Pravachol®

(Pravastatin sodium)

039 Patient has a clinical drug-drug interaction with other statin-type cholesterol-lowering agents.

Pulmozyme®

(Deoxyribonuclease)

053 Diagnosis of cystic fibrosis and the patient is 5 years of age or older.

Rebetol®

(Ribavirin)

010 See criteria for Copegus®.

Prescription Drug Program

Drug	Code	Criteria
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Rebetron® <i>(Ribavirin/interferon alpha-2b, recombinant)</i>	008	Treatment of chronic hepatitis C in patients with compensated liver disease who have relapsed following alpha interferon therapy.
	009	Treatment of chronic hepatitis C in patients with compensated liver disease.
Rena-Vite® Rena-Vite RX® <i>(Folic Acid/Vit B Comp W-C)</i>	096	Treatment of patients with renal disease.
ReVia® <i>(NaltrexoneHCl)</i>	067	<p>Diagnosis of past opioid dependency or current alcohol dependency.</p> <p>Must be used as adjunctive treatment within a state-certified chemical dependency treatment program. For maintenance of opioid-free state in a detoxified person, treatment may be started only after a minimum of 7-10 days free from opioid use. Treatment period must be limited to 12 weeks or less, and the patient must have an absence of all of the following:</p> <ul style="list-style-type: none"> a) Acute liver disease; and b) Liver failure; and c) Pregnancy.



Note: A ReVia® (Naltrexone) Authorization Form [DSHS 13-677] must be on file with the pharmacy before the drug is dispensed. **To download a copy, go to:**

<http://www1.dshs.wa.gov/msa/forms/eforms.html>

Ribavirin	010	See criteria for Copegus®.
Risperdal® <i>(Risperidone)</i>	054	<p>All of the following must apply:</p> <ul style="list-style-type: none"> a) There must be an appropriate DSM IV diagnosis; and b) Patient is 6 years of age or older.

Drug	Code	Criteria
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Ritalin LA® <i>(MethylphenidateHCl)</i>		See criteria for Concerta®.
Roferon-A® <i>(Interferon alpha-2b)</i>	030	Diagnosis of hairy cell leukemia in patients 18 years of age <i>recombinant</i> and older.
	032	Diagnosis of AIDS-related Kaposi's sarcoma in patients 18 years of age and older.
	080	Diagnosis of chronic phase, Philadelphia chromosome (Ph) positive chronic myelogenous leukemia (CML) when treatment started within one year of diagnosis.
	109	Treatment of chronic hepatitis C in patients 18 years of age and older.
Seroquel® <i>(Quetiapine fumarate)</i>	054	See criteria for Risperdal®.
Sonata® <i>(Zaleplon)</i>		See criteria for Ambien®.
Soriatane® <i>(Acitretin)</i>	064	<p>Treatment of severe, recalcitrant psoriasis in patients 16 years of age and older. Prescribed by, or in consultation with, a dermatologist, and the patient must have an absence of all of the following:</p> <ul style="list-style-type: none"> a) Current pregnancy or pregnancy which may occur while undergoing treatment; and b) Hepatitis; and c) Concurrent retinoid therapy.

Prescription Drug Program

Drug	Code	Criteria
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Sporanox®
(Itraconazole) Must not be used for a client with cardiac dysfunction such as congestive heart failure.

047 Use for patients with systemic fungal infections and dermatomycoses.

Treatment of onychomycosis for up to 12 months per nail is covered if client has one of the following conditions:

042 Diabetic foot;

043 History of cellulites secondary to onychomycosis **and** requiring systemic antibiotic therapy; or

045 Fingernail involvement with or without chronic paronychia.

Strattera®
(Atomoxetine HCl) 007 Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD).

Suboxone®
(Buprenorphine/Naloxone) 019 Before this code is allowed, the patient must meet all of the following criteria. The patient:

- a) Is **16** years of age or older;
- b) Has a DSM-IV-TR diagnosis of opioid dependence;
- c) Is psychiatrically stable or is under the supervision of a mental health specialist;
- d) Is not abusing alcohol, benzodiazepines, barbiturates, or other sedative-hypnotics;
- e) Is not pregnant or nursing;
- f) Does not have a history of failing multiple previous opioid agonists treatments and multiple relapses;

Drug	Code	Criteria
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- g) Does not have concomitant prescriptions of azole antifungal agents, macrolide antibiotics, protease inhibitors, Phenobarbital, carbamazepine, phenytoin, and rifampin, unless dosage adjusted appropriately; and
- h) Is enrolled in a state-certified chemical dependency treatment program.

Limitations:

- No more than 14-day supply may be dispensed at a time;
- Urine drug screens for benzodiazepines, amphetamine/methamphetamine, cocaine, methadone, opiates, and barbiturates must be done before each prescription is dispensed. The prescriber must fax the pharmacy with confirmation that the drug screen has been completed to release the next 14-day supply. The fax must be retained in the pharmacy for audit purposes;
- Liver function tests must be monitored periodically to guard against buprenorphine-induced hepatic abnormalities; and
- Clients may receive up to 6 months of buprenorphine treatment for detoxification and stabilization.



Note: A Buprenorphine-Suboxone Authorization Form (DSHS 13-720) must be on file with the pharmacy before the drug is dispensed. **To download a copy, go to:**

<http://www1.dshs.wa.gov/msa/forms/eforms.html>

Symbyax®
(Olanzapine/
Fluoxetine) 048 All of the following must apply:

- a) Diagnosis of depressive episodes associated bipolar disorder; and
- b) Patient is **6** years of age or older.

Prescription Drug Program

Drug	Code	Criteria
Talacen® <i>(Pentazocine/Acetaminophen)</i> Talwin NX® <i>(Pentazocine/Naloxone)</i>	091	Patient must be 12 years of age or older and has tried and failed two NSAIDs or failed one other narcotic analgesic and is allergic or sensitive to codeine.
Toprol XL® <i>(Metoprolol succinate)</i>	041	Diagnosis of congestive heart failure.
Vancomycin oral	069	Diagnosis of clostridium difficile toxin and the patient has failed to respond after two days of metronidazole treatment or the patient is intolerant to metronidazole.
Vitamin ADC Drops	093	The child is breastfeeding and: <ul style="list-style-type: none"> a) The city water contains sufficient fluoride to contraindicate the use of Trivits w/Fl; and b) The child is taking medications which require supplemental Vitamin D, as determined medically necessary by the prescriber and cannot be obtained by any other source.
Vitamin E	105	Confirmed diagnosis of tardive dyskinesia or is clinically necessary for Parkinsonism and all of the following: <ul style="list-style-type: none"> a) Caution is addressed for concurrent anticoagulant treatment; and b) Dosage does not exceed 3,000 IU per day.
Wellbutrin SR and XL® <i>(Bupropion HCl)</i>	014	Treatment of depression.
Zofran® <i>(Ondansetron HCl)</i>		See criteria for Kytril®.

Drug	Code	Criteria
Zometa® <i>(Zoledronic acid)</i>	011	Diagnosis of hypercalcemia associated with malignant neoplasms with or without metastases; or multiple myeloma; or bone metastases of solid tumors.
Zyprexa® Zyprexa Zydis® <i>(Olanzapine)</i>	054	See criteria for Risperdal®.

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